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No. 02-1845

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

REPLY BRIEF FOR PETITIONER

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

TABLE OF CONTENTS

Page

RULE 29.6 STATEMENT i

TABLE OF AUTHORITIES iii

I. This Court's Review Is Warranted To Resolve The Widening Conflict Among The Lower Courts Over The Question Of Complete Preemption 1

A. Davila Proffers Only An Untenable Distinction Between The Decision Below And Cases Following The Majority Rule That ERISA Preempts Supplemental State Remedies 2

B. Recent Decisions Of The Ninth and Eleventh Circuits Have Widened The Divide And Heightened The Need For This Court's Review 6

II. Because Preemption Under Section 502(a) Affects Federal Jurisdiction, That Issue Is Necessarily Antecedent To Any Other ERISA-Preemption Issue 9

CONCLUSION 10

TABLE OF AUTHORITIES

Page(s)

Cases

Agostini v. Felton, 521 U.S. 203 (1997) 6

Boggs v. Boggs, 520 U.S. 833 (1997) 10

Cicio v. Doe, 321 F.3d 83 (2d Cir. 2003), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 03-69 (docketed July 14, 2003) 2, 3, 4, 10

Danca v. Private Health Care Systems, 185 F.3d 1 (1st Cir. 1999) 5

Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) 5

Elliot v. Fortis Benefits Insurance Co., 337 F.3d 1138 (9th Cir. 2003) 7, 8

Hotz v. Blue Cross & Blue Shield of Massachusetts, Inc., 292 F.3d 57 (1st Cir. 2002) 5

Jass v. Prudential Health Care Plan, Inc., 88 F.3d 1482 (7th Cir. 1996) 5

Kuhl v. Lincoln National Health Plan of Kan. City, Inc., 999 F.2d 298 (8th Cir. 1993) 5

Land v. CIGNA Healthcare of Florida, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003) 2, 8

Marks v. Watters, 322 F.3d 316 (4th Cir. 2003) 8

Pegram v. Herdrich, 530 U.S. 211 (2000) ..... *passim*

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) 1, 4, 6, 7

Pryzbowski v. U.S. Healthcare, Inc., 245 F.3d 266 (3d Cir. 2001) 5

Rodriguez de Quijas v. Shearson/American Express, Inc., 490 U.S. 477 (1989) 6

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 378 (2002) 7, 8

Steel Co. v. Citizens for a Better Environment, 523 U.S. 83 (1998) 9

Statutes

ERISA § 3(1), 29 U.S.C. § 1002(1) 2

ERISA § 409, 29 U.S.C. § 1109 3

ERISA § 502(a), 29 U.S.C. § 1132(a) ..... *passim*

ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) 7, 8

ERISA § 514, 29 U.S.C. § 1144 ..... 9, 10

Court Documents

Brief for Respondent Aetna Health Inc., *Roark v. Humana, Inc.*, No. 02-1826 (filed July 7, 2003) 9

Brief for the United States, *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (Nov. 7, 2001) 3

REPLY BRIEF FOR PETITIONER

The Fifth Circuit's decision in this case creates a categorical exemption from ERISA's exclusive remedial scheme for any state cause of action sounding in tort. That holding is contrary to all of this Court's decisions considering "complete preemption" under ERISA § 502(a), and to the majority of decisions of the courts of appeals, most of which adhere to this Court's holding that tort claims are preempted as supplemental remedies rejected by Congress. Respondent Davila defends the judgment below by attempting to invent further subcategories of medical torts and health-benefit decisions that enjoy such categorical immunity from preemption. Although a minority of the courts of appeals has accepted these purported distinctions, they are without support in this Court's cases. Because of the significance of complete preemption for federal jurisdiction as well as uniform national benefit-plan administration, plenary review by this Court is sorely needed to resolve the deepening divide over Section 502(a)'s preemptive effect.

I. This Court's Review Is Warranted To Resolve The Widening Conflict Among The Lower Courts Over The Question Of Complete Preemption

This Court has made clear, and most lower courts have dutifully accepted, that a State may not supplement the remedies available in a challenge to a benefits-administration decision. *E.g.*, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-54 (1987); Pet. 19-25. The decision below deviates from that rule by creating an unsupported exception for any state-law claim that seeks a remedy in tort. Pet. App. 16a-17a. That broad holding, as the petition demonstrates, is altogether at odds with *all* of this Court's complete-preemption cases and with the decisions of a majority of other circuits. Pet. 10-28.

A. Davila Proffers Only An Untenable Distinction Between The Decision Below And Cases Following The Majority Rule That ERISA Preempts Supplemental State Remedies

Davila seeks to explain away the divide between the decision below and the numerous holdings (by this Court and others) with which that decision conflicts by asserting that a different preemption rule applies to tort claims related to *health* benefits and asserted under (variously) state negligence law, state malpractice law, or a state HMO-regulation statute.[1] Opp. Br. 14-15. Such a distinction is untenable as a matter of law: nothing in ERISA or this Court's cases countenances carving an exception from ERISA's nationally uniform framework for plan-administration decisions that involve medical benefits. *Cf.* ERISA § 3(1), 29 U.S.C. § 1002(1) (definition of "employee welfare benefit plan" does not differentiate among health, disability, vacation, or other benefits). Davila's assertion that the cases with which the decision below conflicts are off point because they do not involve health benefits and "mixed eligibility and treatment decisions" simply assumes that these distinctions have some legal significance in the preemption context. That assumption is faulty.

1. Davila's proposed distinction is based on a misreading of this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), a case whose context-specific holding did not turn on the preemption of state law at all. *E.g.*, *Cicio v. Doe*, 321 F.3d 83, 109 n.4 (2d Cir. 2003) (Calabresi, J., dissenting)

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[1] *See Land v. CIGNA Healthcare of Fla.*, No. 02-15549, 2003 WL 21751247, at *1 (11th Cir. July 30, 2003) (negligence), *cited in* Opp. Br. at 18-20; *Cicio v. Doe*, 321 F.3d 83, 90 (2d Cir. 2003) (malpractice), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 03-69 (docketed July 14, 2003), *cited in* Opp. Br. at 15-18; Pet. App. 5a (HMO-regulation statute).

("*Pegram*, of course, was not a preemption decision."), *petition for cert. filed sub nom. Vytra Healthcare v. Cicio*, No. 03-69 (docketed July 14, 2003). In *Pegram*, this Court considered whether a patient stated a claim for breach of fiduciary duty under ERISA by alleging that her *physician-owned* HMO had considered cost-containment factors in prescribing her course of treatment. *E.g.*, 530 U.S. at 220, 222, 227-28. Because in that case, the HMO owners who made coverage determinations were also the treating physicians, the same person necessarily made the "eligibility" and "treatment" decisions. *Id.* at 229-30. The Court rejected the notion that ERISA provides a cause of action for breach of fiduciary duty against *physicians*, or HMOs that employ them directly. *Id.* at 235-37. "[M]ixed eligibility decisions *by HMO physicians*," the Court held, are not fiduciary decisions within the meaning of ERISA § 409, 29 U.S.C. § 1109. *Pegram*, 530 U.S. at 237 (emphasis added).

Davila's error is to assume that *all* coverage decisions relating to health benefits are always and everywhere "mixed eligibility and treatment decisions." Because most coverage decisions relating to health benefits have some medical ingredient—no payment ordinarily is available unless a particular treatment is medically "necessary" under criteria established by the plan—Davila concludes that an HMO necessarily engages in "treatment" that is "mixed" with its "eligibility" judgment whenever it decides not to pay for a procedure recommended by the treating physician. But as the Solicitor General recently noted before this Court, while "[s]ome statements in *Pegram*, if read in isolation, might suggest that such 'mixed decisions' . . . are never fiduciary acts under ERISA, . . . [t]he better reading of *Pegram* . . . is that it addresses only mixed decisions made by *treating* physicians." Brief for the United States as Amicus Curiae at 8, *Rush Prudential HMO, Inc. v. Moran*, No. 00-1021 (Nov. 7, 2001). Indeed, any other reading of *Pegram* would run contrary to "the background provisions of ERISA itself and

longstanding Labor Department regulations." *Id.* at 9; *see also Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting). In Davila's view, by contrast, it would appear that a plan administrator's health coverage decisions or policies are *never* fiduciary in nature, since they are likely to include *some* "medical" component.

There is a world of difference between a treating doctor's cost-based decision not to *order* an ultrasound at a nearby hospital (*Pegram*, 530 U.S. at 215), and a plan administrator's decision not to *pay for* a procedure that a physician recommends or performs. In this case, for example, Aetna did not purport to decide what drug would be the "appropriate medical response" to Davila's arthritis (Opp. Br. 13 (quoting *Pegram*, 530 U.S. at 228)); rather, it merely made the coverage decision that, absent contraindication or participation in the "step program," the Monitronics plan did not authorize *payment* for Vioxx. *See* Pet. 3 & n.2. Davila cannot bridge that wide gap merely by asserting that Aetna's decision not to pay for a medication prescribed by a non-employee doctor should be re-labeled as medical "treatment."

Thus, Davila's assertion that the decision below cannot be said to conflict with any decision of the First, Third, Fourth, Eighth, Tenth, or any other circuit that does not involve "mixed eligibility and treatment decisions" is wholly spurious. Neither this case nor *any* of the cases discussed in the petition involved benefits administrators who also make decisions about medical *treatment*. Rather, *all* of the cases on both sides of the divide involved plan beneficiaries who sought to challenge decisions about plan administration—and in particular decisions not to pay for assertedly "necessary" treatments or procedures—through state-law causes of action. Most of these courts held that those state-law claims are completely preempted under *Pilot Life* and its progeny. Pet. 20-25. The Fifth Circuit in this case took the contrary view. It would be difficult to posit a starker circuit conflict.

2. Davila is also wrong to suggest that the *Pegram* Court somehow discovered for the first time that health benefits administration may turn on antecedent medical judgments about whether a treatment is necessary or appropriate under the circumstances. *See* Opp. Br. at 14-15, 23. Well before *Pegram*, the courts of appeals had uniformly recognized that a basic feature of health insurance in the HMO setting is that HMOs agree to reimburse only "medically necessary" services. *See, e.g.*, *Danca v. Private Health Care Sys.*, 185 F.3d 1, 5-6 & n.5 (1st Cir. 1999); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1489 (7th Cir. 1996); *Kuhl v. Lincoln Nat'l Health Plan of Kan. City, Inc.*, 999 F.2d 298, 303 (8th Cir. 1993). Indeed, *Pegram*'s discussion of this point drew on a leading decision from the Third Circuit, *see Pegram*, 530 U.S. at 227-28 (citing *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995)), a court that continues to produce decisions at odds with the decision below. *See Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 273-75 (3d Cir. 2001); Pet. 21-22.

In *Danca*, for example, the First Circuit specifically noted the "quasi-medical" character of a decision not to precertify treatment recommended by the beneficiary's treating physician. Nonetheless, the court held completely preempted a claim for tort damages attributed to that decision, because the challenged "conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan." 185 F.3d at 6. Unlike the Fifth Circuit in this case, the First Circuit has not found anything in *Pegram* that warrants revisiting that conclusion: it recently reaffirmed *Danca*. *See Hotz v. Blue Cross & Blue Shield of Mass., Inc.*, 292 F.3d 57, 60 (1st Cir. 2002). Davila does not so much as mention *Danca*, and he attempts to distinguish *Hotz* solely on the ground that (although it also arose from a failure to precertify health coverage) it involved a different "tort" from the ones he alleges (Opp. Br. at 23 n.10)—a distinction that

would appear irrelevant in light of the broad "tort-contract" divide that the Fifth Circuit adopted in the decision below.

In the end, Davila's *Pegram* arguments are not only legally insubstantial, but also completely inadequate to avoid certiorari. This Court made clear in *Pegram* itself that it was not passing on any preemption question, and thus nothing in *Pegram* can justify the Fifth Circuit's decision to depart from the consistent course of this Court's "complete preemption" decisions, which spans 15 years from *Pilot Life* to *Rush Prudential*. In each of the four such cases that received this Court's plenary consideration, *every* Justice who participated espoused a rule of law that is concededly at odds with the decision below. Even if Davila could plausibly argue that *Pegram* suggests the need to reconsider those decisions (and he cannot), the Fifth Circuit could not properly agree with him. *See Agostini v. Felton*, 521 U.S. 203, 237 (1997); *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989).

B. Recent Decisions Of The Ninth and Eleventh Circuits Have Widened The Divide And Heightened The Need For This Court's Review

The significant and entrenched division among the courts of appeals has widened even during the pendency of this petition: the Ninth and Eleventh Circuits recently joined the fray, taking opposite sides. The Ninth Circuit recognized that state-law claims seeking damages not available under ERISA § 502(a) are preempted when the challenged conduct is an ERISA plan administrator's decision whether to pay benefits under the terms of the plan. The Eleventh Circuit, by contrast, recently announced a *Pegram*-based preemption doctrine similar to the one adopted by the Fifth Circuit in this case. These decisions make even clearer that, until this Court resolves the issue, the division among the courts of appeals will continue to frustrate ERISA's goal of a uniform, nationwide regime of benefits administration.

1. In *Elliot v. Fortis Benefits Insurance Co.*, 337 F.3d 1138 (9th Cir. 2003), the Ninth Circuit held that *Pilot Life*'s core holding continues to govern claims against a plan administrator relating to the administration of benefits. Fortis terminated Elliot's disability benefits because her cancer resulted from a pre-existing condition and thus was excluded under the plan. *Id.* at 1141. Elliot sued in tort under a Montana unfair-claim-settlement statute that allowed recovery of punitive damages. *Id.* at 1147. The Ninth Circuit held the claim completely preempted by Section 502(a). *Id.*

Notably, *Elliot* took a position directly contrary to the decision below—and faithful to this Court's precedents—in holding that a state-law claim may be preempted as a supplemental remedy even if it does not *precisely duplicate* one of Section 502(a)'s rights of action. In the Ninth Circuit's view, an action that "seeks non-ERISA damages for what are essentially claim processing causes of action, *clearly* falls under the § 1132 preemption exemplified by *Pilot Life*." *Elliot*, 337 F.3d at 1147 (emphasis added). And the Ninth Circuit noted that this Court had recently reaffirmed that Section 502(a) preempts "'the sort of additional claim *or remedy* exemplified in *Pilot Life*.'" *Id.* (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 378, 380 (2002)) (emphasis added). The Montana statute sought to give just such an additional remedy; like the THCLA in this case, it "provides damages above and beyond those provided in ERISA, including punitive damages." *Id.*

Elliot, which Davila does not mention, is directly contrary to the decision below. The Fifth Circuit, misreading this Court's decision in *Rush Prudential*, held that precise duplication of a Section 502(a) cause of action is the *sine qua non* of complete preemption, and it even held that Davila's THCLA claim was not completely preempted *because* it sought tort damages not available under ERISA, rather than lost benefits recoverable under Section 502(a)(1)(B). Pet.

App. 17a, 20a. As the petition explains, that holding misunderstands *Rush Prudential* and is also at odds with this Court's complete-preemption cases. *See* Pet. 15-16 & n.5, 18. Davila seeks to defend the erroneous holding by pointing to a passage in *Rush Prudential*. *See* Opp. Br. 9. But the *Elliot* court specifically rejected the identical argument and explained why a requirement of precise duplication, like the Fifth Circuit's, is actually *contrary* to *Rush Prudential* and this Court's other cases. *See Elliot*, 337 F.3d at 1147.[2]

2. Also recently, in *Land v. CIGNA Healthcare of Florida*, No. 02-15549, 2003 WL 21751247 (11th Cir. July 30, 2003), the Eleventh Circuit held that a plan administrator's pre-approval decision (denying the beneficiary inpatient treatment) was a "mixed decision of eligibility and treatment." *Id.* at *1, *6. The court stated (citing the decision below with approval) that actions challenging such decisions are not "claims 'to recover benefits' under section 502(a)(1)(B)," because claims under ERISA are contractual in nature, whereas Land's claims were "tort claims based upon the duty of care" and were "not challenging a denial of benefits." *Id.* at *6 & nn.5-6 (citing Pet. App. 16a-17a).[3]

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[2] The benefits decision at issue in *Elliot* also involved an aspect of medical judgment, just as was true in this case and many of the court of appeals cases on both sides of the divide. Indeed, the plan administrator relied on Elliot's own oncologist in determining that her cancer had metastasized from a pre-existing condition. *Elliot*, 337 F.3d at 1141. Yet because Fortis was not providing Elliot's medical care, but only *paying* for her care, its decision cannot be considered a mixed eligibility and treatment decision under the narrowly applicable *Pegram* framework, for the simple reason that Fortis provided no treatment (as is true of Aetna in this case).

[3] The Eleventh Circuit also cited *Pryzbowski* and *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), but as the petition discusses, those cases *reject* the notion that the medical consequences of a plan administrator's coverage decision place it in a new category free from preemption. Pet. 20-22.

These recent decisions confirm that the courts of appeals are profoundly divided on the question of complete preemption, and that this Court's intervention is urgently needed.

II. Because Preemption Under Section 502(a) Affects Federal Jurisdiction, That Issue Is Necessarily Antecedent To Any Other ERISA-Preemption Issue

In the vast majority of cases involving the distinct forms of ERISA preemption under Section 502(a) and Section 514, the Section 502(a) issue is logically considered first. Davila disputes this proposition in an attempt to bolster the certworthiness of a petition raising the Section 514 issue that his counsel of record has filed in a companion case (*Roark v. Humana, Inc.*, No. 02-1826) arising out of the same Fifth Circuit decision—a case in which this Court's jurisdiction would depend on the correctness of the jurisdictional analysis adopted by the Fifth Circuit in dealing with the "complete preemption" question in this case. Opp. Br. at 1 n.1, 8 n.6. Under those circumstances, the Constitution *requires* that the federal court adjudicate the jurisdictional question first. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 93-102 (1998). For the court to bypass the Section 502(a) issue and resolve the case on Section 514 grounds would be, "by very definition, for [the] court to act *ultra vires*." *Id.* at 102.[4] In-

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[4] The court below addressed these questions in the correct order: only *after* concluding that Section 502(a) conferred jurisdiction but did not resolve all of the plaintiffs' claims did the court move on to Section 514(a). *See* Brief for Respondent Aetna Health Inc. at 3-4, *Roark v. Humana, Inc.*, No. 02-1826 (filed July 7, 2003). Likewise, if this Court grants review in this case and concludes that some but not all aspects of Davila's claim are completely preempted, it would then be able to address the Section 514 defense that Aetna pressed in the courts below.

deed, prudential considerations also support examining the potentially dispositive Section 502(a) issue first. As this Court has previously held, a conflict with a *substantive* portion of ERISA (such as Section 502(a)'s exclusive remedial provisions) obviates any need to examine whether a state law also transgresses the more diffuse directives of Section 514. *See Boggs v. Boggs*, 520 U.S. 833, 841, 844 (1997).

For this reason, this Court should grant review in a case that presents the Section 502(a) question. This question is most directly presented in this case and its companion, *CIGNA Healthcare of Texas, Inc. v. Calad*, No. 02-83 (a case that largely incorporates the arguments presented in the petition in this case); it is also presented in *Cicio*, No. 02-69, and superficially in *Conover v. Aetna Inc.*, No. 02-1864 (although the petition in the latter case fails to argue, and thus waives, the Section 502(a) issue). In *Cicio*, the HMO excluded the proposed treatment under the terms of the plan on the ground that it was "experimental," as distinct from "unnecessary." 321 F.3d at 88. Accordingly, *Cicio* does not present the Section 502(a) issue in the factual context in which it most frequently arises, and this Court's resolution of *Cicio* might provide less relevant guidance to the lower courts dealing with "medical necessity" questions than would the disposition of this case. Nonetheless, we believe that both *Cicio* and *Calad* are better vehicles for the resolution of the questions that currently divide the federal courts of appeals than is *Roark*. In the event the Court elects not to give plenary consideration to (or summarily reverse) the judgment in this case, we respectfully suggest that certiorari should be granted in *Cicio* or *Calad*.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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